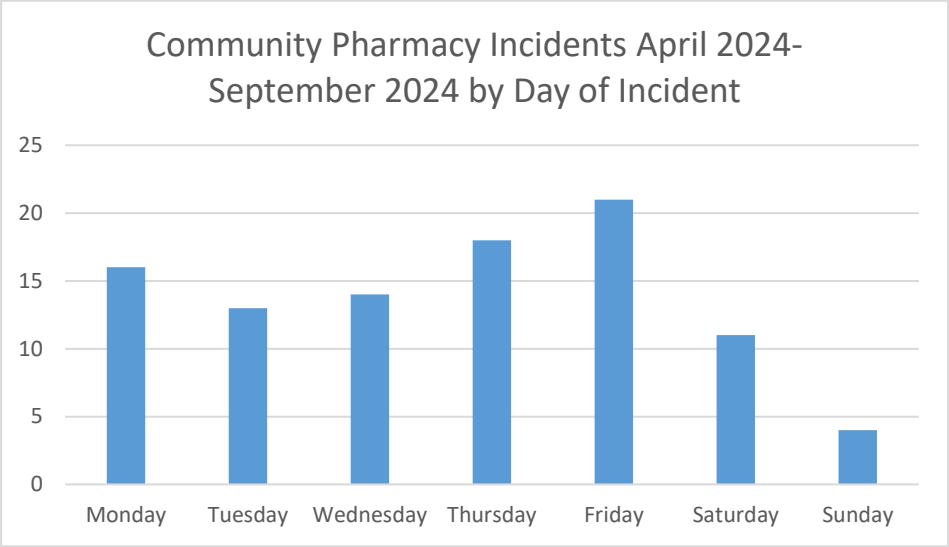
The following trends have been identified following analysis of controlled drug incidents reported to NHS Grampian controlled drugs team from April 2024 to September 2024.




Community pharmacies reported 70 controlled drug incidents between October 2023 and March 2024. From April 2024 to September 2024, 97 controlled drug incidents were reported. For this latter period, the top three drugs involved were:

Methadone

Methylphenidate

Morphine

The top three incidents reported were:

Dispensing errors

Handout errors

Unexplained loss/missing controlled drugs

A comprehensive review of the controlled drug **dispensing errors** revealed that the majority resulted due to an error in the quantity supplied to patients. On occasion this was identified following a controlled drug check at a later date. Community pharmacists are encouraged to reflect on their dispensing and checking process to prevent such errors occurring. A balance check of the controlled drug stock remaining after each item is dispensed is recommended. Please also be vigilant when dispensing original packs as they often contain 30 as opposed to 28 solid oral dosage forms and this is frequently cited as the source of the error. Dispensing the incorrect strength and formulation are the second and third most frequently reported cause of dispensing errors respectively. Community pharmacists are requested to review their storage arrangements for controlled drugs to ensure there is adequate segregation of different strengths and formulations to minimise the risk of selecting the wrong product.

Community pharmacists are reminded that if a **handout error** occurs, both patients should be informed that their data has been shared with another patient. Handout errors result if the patient's identity is not confirmed prior to providing medication. Community pharmacists are requested to review their process for patient identification and ensure all staff are aware of the essential checks for **every** patient receiving prescribed medication.

Reports of **unexplained loss/missing controlled drugs** are often thought to be attributed to packaging inadvertently being placed in the bin when it is not empty. As above, verifying that the physical balance remaining in the controlled drugs cupboard is correct after each item is dispensed should alert staff of a potential loss. Community pharmacists should also reflect on how they dispose of controlled drugs packaging and consider whether there is an opportunity for another member of staff to confirm that the packaging is empty and there are no small strips of foil contained in the patient information leaflet.